Presentation to the Blue Ribbon Commission on Child Protection

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casey family programs

fostering families. fostering change.

LA county youth and families in need

Well-Being require safety

- Behavioral health prevalence data
- Child welfare data
- Poverty data

casey family programs

Estimate of Need LA County

SMI Definition

2009

	Total Population			Households below 200% poverty		
Total Pop	Cases	Pop	Percent	Cases	Pop	Percent
Total Population	**525,468**	**9,848,011**	**5.34**	**308,881**	**3,850,659**	**8.02**
Youth total	**195,233**	**2,502,787**	**7.8**	**113,979**	**1,273,470**	**8.95**
00-05	67,689	866,328	7.81	40,516	452,385	8.96
06-11	62,631	809,543	7.74	38,167	426,163	8.96
12-17	64,914	826,916	7.85	35,296	394,922	8.94
Male	100,237	1,281,034	7.82	58,168	650,095	8.95
Female	94,996	1,221,753	7.78	55,811	623,376	8.95
White-NH	31,026	454,209	6.83	8,460	95,346	8.87
African Am-NH	15,851	196,228	8.08	9,362	101,938	9.18
Asian-NH	17,431	242,361	7.19	7,159	80,550	8.89
Pacific I-NH	473	5,896	8.03	284	3,142	9.03
Native-NH	364	4,516	8.06	219	2,446	8.96
Other-NH	0	0	0	0	0	0
Multi-NH	4,261	57,412	7.42	1,901	20,865	9.11
Hispanic	125,828	1,542,166	8.16	86,594	969,184	8.93
Below 100%	60,673	606,749	10	60,509	605,086	10
100%-199%	53,476	668,451	8	53,471	668,385	8
200%-299%	29,706	424,371	7	0	0	0

http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

In FY 2013

- 58.7% of youth in LA County foster care were there with a diagnosed disability or with a removal reason of disability

- 30.0% were there due to parent's inability to cope

Healthcare that supports child safety

- Screening and assessment
  - Identification of need
  - Specific information on acuity
  - Various delivery locations: primary care, pediatricians, RNs, mental health clinics
- Evidence-based practices
  - Attend to identified need
  - Clinic, congregate care and community-based
- Coordinated health care: TCM and others

What Medi-Cal pays for:

- EPSDT
  - Screening and assessment
  - Treatment
  - Periodic re-evaluation
- Evidence-based practices (In-Home Based Services)
  - Therapeutic Foster Care
- Coordinated health care (Intensive Care Coordination)

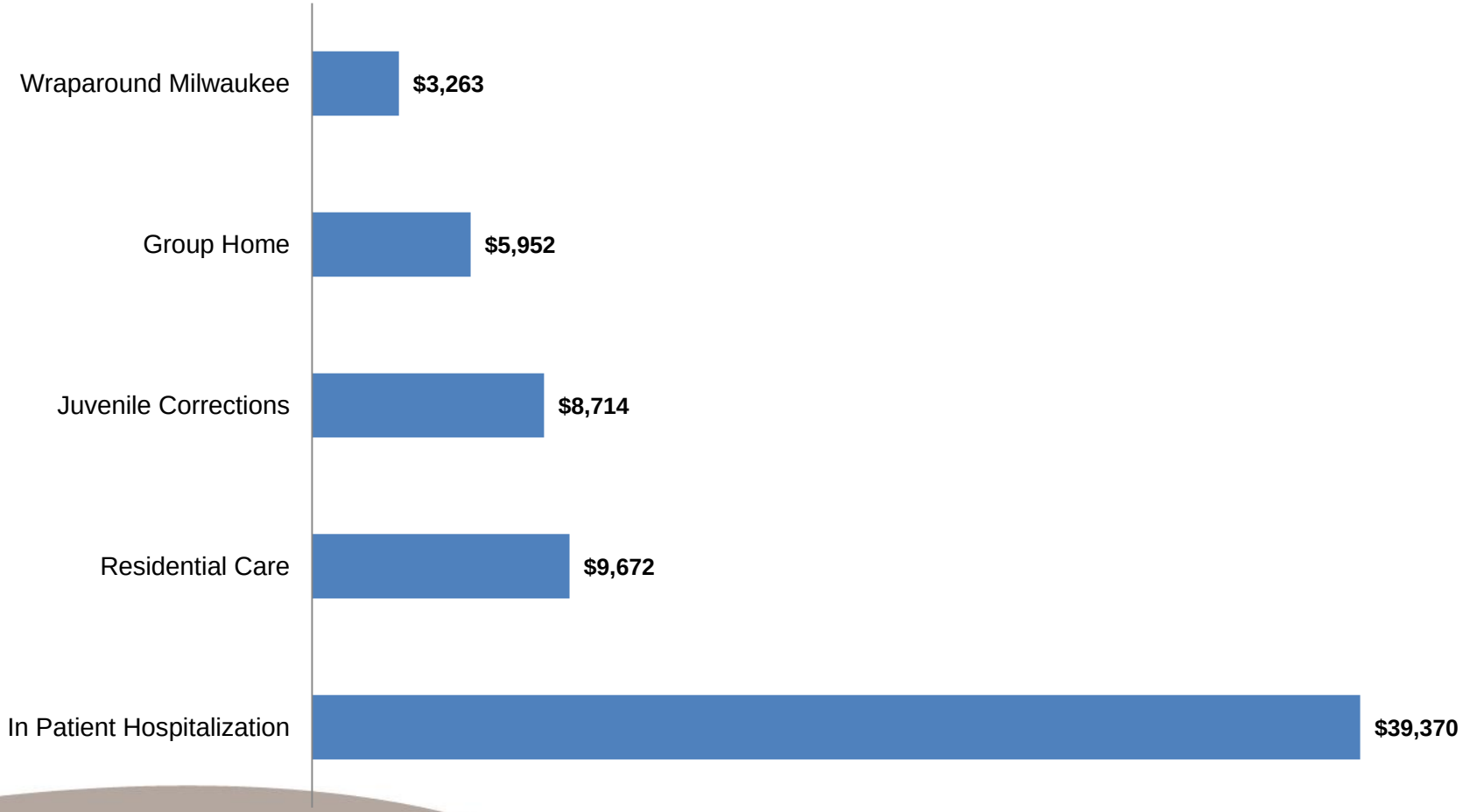
Requisite Elements

- Shared accountability
- Data-driven decision making and resource allocation
- A focus on Quality
- Discrete and clearly identified pathways for child welfare
- Leadership

Wraparound Milwaukee

- County based
- $ from Medicaid, Delinquency and Court Services, and a Case Rate from CW
- Significant savings in cost of care and well-being outcomes

How much it costs per month



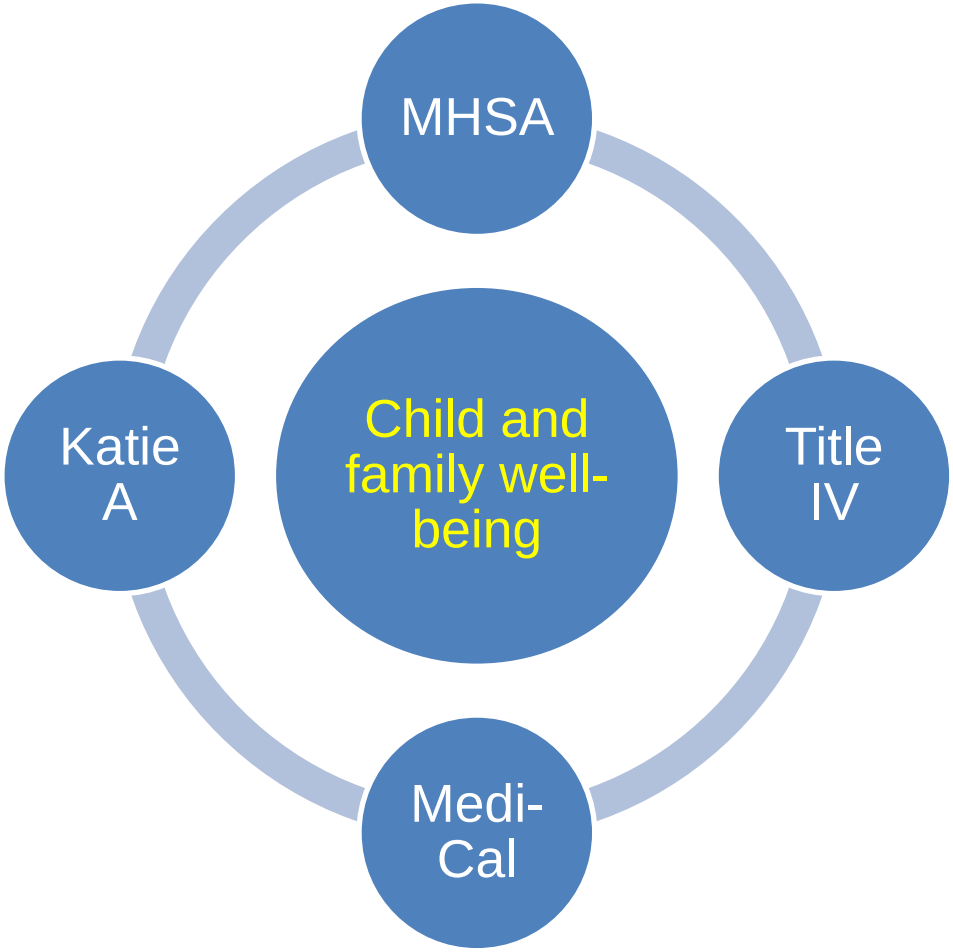
Advice from Michigan

- Cover a **broad array** of services and supports under the state Medicaid plan to ensure that they are adequately financed and sustainable.
- Create an **administrative structure** at the state level, with both a core operational team and a policy leadership team across child welfare, Medicaid, behavioral health, and other key agencies.
- Demonstrate with **data** that the Medicaid behavioral health system can deliver the services needed by the child welfare population and achieve good outcomes.
- Incorporate **behavioral health staff at the front line** to help child welfare staff assess the need for behavioral health intervention, determine appropriate services, and link with providers.
- Incorporate **child welfare liaison staff** with expertise in Medicaid to facilitate enrollment when a child enters foster care, ensure that children are linked with primary care providers, and provide feedback to policy makers about needed improvements in access to physical health and behavioral health services.
- Ensure that the **partnership includes state and local stakeholders**, both of which are needed to implement strategies to improve services, particularly in a county-run system.
- Include **evidence-based practices** that are relevant for the child welfare population in the array of covered services and supports.
- **Monitor Medicaid claims data** against the foster care population and measure service utilization and outcomes for this group of children

http://www.chcs.org/usr_doc/Making_Medicaid_Work.pdf

Quality Binds

- Reduction in the number of children with a clinical level of need receiving no services;
- Increase in the number of children receiving evidence-based screening, assessment and treatment;
- Reduction in the use of “deep-end” services, including emergency department visits for acute crisis stabilization and residential treatment for extended periods;
- Reduction in the use of psychotropic medication prescribing practices that do not conform with the American Academy of Child and Adolescent Psychiatrists Practice Parameters;
- Reduction in the number of psychotropic medications prescribed and a reduction in the total number of youth with prescriptions for psychotropic medications;
- Reduction in the use of foster home placements to include re-entries into care;
- Net increase of Medicaid-participating EBP-trained clinicians; and
- Improvements in child functioning across well-being domains and reductions in trauma symptoms.



Quality *Outcomes* *Shared Accountability* *Data*